State of Colorado - Risk Management Office
EMPLOYMENT CLAIM TRACKING FORM

Agency Name

Employee Name

Org ID (cofrs)

Gender

Report Date: _____

Type:

Agency Contact

- ☐ Initial
- ☐ Interim
- ☐ Final

Date of Birth

Phone Number

Date of Hire

Address

City, State, Zip

Social Security #

Claim Origination Date: _____

Leave Granted in Equivalent $: $ _____

Agency $ Payments (to date): $ _____

Brief Description of Situation:

Nature of claim (check one or more)

- ☐ Due Process
- ☐ Retaliation
- ☐ ADA (Americans w/ Disabilities)
- ☐ Discrimination (specify) _____
- ☐ Sexual Harassment
- ☐ Hostile Work Environment
- ☐ Whistleblower
- ☐ Other (specify) _____

Claim Jurisdiction:

- ☐ Grievance
- ☐ Personnel Director/Board
- ☐ Appointing Authority
- ☐ State Court
- ☐ Federal Court
- ☐ Other (specify) _____

Claim Findings:

- ☐ Discipline
- ☐ Termination
- ☐ Retirement
- ☐ Resignation
- ☐ Transfer
- ☐ Administrative Leave
- ☐ Undetermined
- ☐ No Change
- ☐ Denied/Dismissed
- ☐ Other (specify) _____

HOW TO USE THIS FORM:

WHAT: An employment claim involves the potential for or actual payment of a damage settlement.
WHY: Pursuant to 24-30-1504, C.R.S., employment claim information must be reported to Risk Management.
WHO: The agency contact may be the agency appointing authority or designee.
WHEN: Complete as soon as an employment claim situation is identified. Supplement at 90-day intervals.
WHERE: Submit by **MAIL ONLY** to:

State Risk Management Office
Attn: ECT Unit (Confidential)
1313 Sherman St., #114
Denver, CO 80203

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